Recording what happens in the under-16 consultation
Pauline McGough, Chris Thow, Ambreen Butt, Myra Lamont, Alison Bigrigg

Abstract
Background Clinical staff offering sexual health services to young people need to balance the rights of the young person to confidentiality and good quality advice with the need to protect their wider interests. The needs of young clients may be complex and raise ethical and medico-legal questions for the staff involved in their care.

Methods In our large, integrated sexual health service, a ‘recording form’ was introduced to prompt staff to record data systematically pertinent to consultations in clients under 16 years of age, to understand what kind of presentations dominate in these consultations, and to establish how common child protection concerns are.

Results From April to October 2004, more than 500 forms were completed in our service. The age range for female clients was 12–15 years, with the median age of first sexual intercourse 14 years. Most respondents were in consensual relationships with partners of around their own age, but 10% had been in relationships of less than a week’s duration. Most had not told their parents of their sexual activity and did not intend to. Child protection issues did occur, although not commonly.

Conclusions Most clients initially present requesting emergency contraception or pregnancy testing, and the inference is that unprotected sexual intercourse is common in this group of clients before they seek our services. The need for confidential sexual health services for young people are under threat.7

Key message points
- Child protection issues need to be delicately balanced with the rights of the child in the care of sexually active young people.
- The majority of consultations do not raise immediate child protection issues, but answers to some questions may increase concerns about particular clients.
- Training of staff and the introduction of a proforma can prompt the systematic recording of information and may improve staff confidence.

Context
The sexual health of young people has been highlighted with the publication of The National Strategy for Sexual Health and HIV6 in England and Wales and Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health2 in Scotland.

Although sexual activity under the age of 16 years is considered illegal, the National Survey of Sexual Attitudes and Lifestyles (NATSAL) 2000 reported that on average 30% of males and females had had their first heterosexual experience when younger than 16 years of age.3

Practitioners in the field of sexual and reproductive health have long balanced the rights of young people to a confidential service that makes their choices with the need to safeguard vulnerable young people. Guidance from the Department of Health Teenage Pregnancy Unit for England4 and the Clinical Effectiveness Unit of the Faculty of Family Planning and Reproductive Health Care5 have emphasised the importance of building trust and rapport with young clients, and the right of the young person to confidentiality in most circumstances (Box 1).

In these challenging times, traditional practice with regard to confidentiality is under the spotlight. Recent rulings in child protection cases and the publication of the recommendations of the Bichard Inquiry6 have prompted providers of services for sexually active young people to examine whether they are achieving the right balance of providing a confidential service, while sharing information with other agencies when that would be in the best interest of the young person concerned. The changing climate may mean that confidential sexual health services for young people are under threat.7

National guidelines for the management of suspected sexually transmitted infections (STIs) in young people recommend a proforma to act as an aide memoire for staff and to facilitate audit.10 Clinicians who introduced such a proforma for underage attendees at a genitourinary medicine (GUM) clinic felt that the proforma helped them to observe trends in this age group.11 Most young people are not seen in the GUM setting, however, but in general practice, family planning clinics or youth health services.

Box 1: The Fraser guidelines
The Fraser guidelines are a set of criteria often used to assess whether a young person can be provided with confidential services without parental consent.8

These guidelines state that a professional would be justified in giving treatment without parental knowledge, provided he/she is satisfied:

- That the young person can understand the advice, and has sufficient maturity to understand what is involved in terms of the moral, social, and emotional implications.
- That he/she cannot be persuaded of the value in informing their parent that contraceptive advice is being sought.
- That the young person is likely to begin/continue having sex with or without contraception.
- That without treatment the young person’s physical/mental health is likely to suffer.
- That the young person’s best interests require contraceptive advice, treatment or both without parental consent.

Additionally, the client needs to demonstrate that he/she is competent to give consent. The client’s decision should be made freely and without pressure.

The Children (Scotland) Act 1995 states that all health care workers have a statutory responsibility to protect a child and inform relevant authorities if a young person is being harmed or is at risk of harm (from sexual, physical or emotional abuse).
Setting
Glasgow has one of the worst health records in Europe, with 25% of the most deprived postcodes in Scotland, and a high rate of teenage pregnancy. The Sandyford Initiative is a large, integrated sexual and reproductive health service that also provides counselling, information and support services. Within the Sandyford Initiative, ‘The Place’ is a service for young people aged 20 years and under, which aims to provide a comprehensive, confidential sexual and reproductive health service for young people in an informal setting delivering a social model of health. It is staffed by a dedicated multidisciplinary team. Clients self-refer or are referred by a number of voluntary and statutory organisations. Approximately 31% of attendances at the Sandyford Initiative are by male clients. Young people aged under 16 years are welcome at any of the Sandyford Initiative services, but 65% of all attendances of clients under 16 are at dedicated sessions at The Place. Approximately 3% of all clients are under 16, and of these only 2.3% are male.

Objectives
The study objectives were as follows:
- To introduce and evaluate a way of prompting staff to record data systematically pertinent to consultations in clients under 16 years of age.
- To understand what kind of issues are important in consultations with clients under 16.
- To establish how frequently child protection concerns such as non-consensual sex, coercive relationships and much older partners are raised in this type of ‘real-life’ consultation.

Study design and intervention
A ‘recording form’ was developed for use in all clinical consultations with Sandyford Initiative clients aged under 16 years (Box 2). The aim was to prompt staff to ask additional questions relevant to clients under 16, and to gather a profile of the nature of consultations with clients under 16 years of age. Information was recorded about age of partner, length of relationship with partner, consent to most recent sexual activity, and age at first sexual activity, in addition to the clinical and social history questions asked at all consultations.

Purpose of the recording form
The purpose was to establish a fuller profile of the young people accessing The Place and the type of relationships they were in. It was also expected that information from the recording forms could be used to identify clinical concerns that may require further discussion and support. Anonymised, summarised information from these forms could also form part of the regular reports to the local child protection committee.

Developing the recording form
The form was drafted by a small group of doctors and nurses working at The Place, and piloted before modification and testing at young people’s clinics. Further comments were invited from staff, and a final version was distributed to all clinic settings within the Sandyford Initiative in December 2003.

Introducing the recording form
In October and November 2003, two of the regular multidisciplinary training sessions were devoted to informing all Sandyford staff of the newly developed written policies on the management of sexually active young people and confidentiality, the local guidance for staff on child protection issues, and the new introduction of the recording form for consultations with clients aged under 16 years. Staff were requested to complete a recording form for each attendance of a client under 16.

Collection and analysis of data from the recording form
All the forms were placed in a secure area to be reviewed by an experienced clinician (initially P.McG. and A.B.). These forms were reviewed regularly, usually within 2 days of the form being returned. Any additional action required was taken (e.g. ensuring that a pregnant client attended her next appointed appointment) and then information from the form entered into a secure Access database. During the pilot data entry was done by one of the authors (P.McG.) and later by medical records staff. The forms were then re-filed in the client’s notes for future reference. Data were then collated and anonymised, and linked to clinical outcomes in the Sandyford Initiative electronic records system. The electronic records system also provides routine reports on numbers of attendances, tests performed and other clinical information.

Results
During the time period April–October 2004, 558 female and 17 male clients aged under 16 years attended the Sandyford Initiative for a total of 991 attendances. Forms were completed for 54.6% of all attendances of female clients aged under 16 years. There were very few young men attending the service over the same time period, and forms were returned for 26.9% of all these attendances (Table 1). Because these numbers are so small, further results are presented for female clients only.

The median number of visits per client was one (range, one to seven). Some 53% of clients for whom forms were returned attended once only in the timeframe studied. Completion of forms was better at dedicated young people’s sessions (68.9%) than at other Sandyford services.
(35.7%). Staff were as likely to return forms for repeat clients as new clients, but over the time period studied only 73% of visits were for clients with at least one under-16 recording form completed.

**Age of clients**

The median age of clients for whom forms were returned was 15 (range, 12–15) years. Staff were more likely to return forms from older clients (see Table 2).

**Reason for presentation**

Most female clients presented for emergency contraception or pregnancy testing (Table 3). Often more than one problem was addressed at the visit, but the first problem listed on the recording form has been assumed to be the most pressing to the client. The reasons for presentation were broadly similar across the age groups, and were no different for return visits or initial consultations. Younger clients (i.e. those aged under 14 years) were slightly more likely to present for health information and to present once only in the timeframe under discussion, but none of these differences were significant.

**Length of relationship**

In 89.4% of attendances, information was recorded about the length of the current sexual relationship. This ranged from single casual encounters to 3 years (Figure 1). The most frequent individual response was 6 months. This does not always equate with the initiation of sexual activity within that relationship, and this was not specifically recorded. If there was no recent sexual activity this was usually recorded as not applicable.

**Age of partner**

The age of the partner was recorded in years, and the difference between partners’ and clients’ ages is summarised in Table 4. For 58.4% of female attendances, the partner’s age was within a year of the client’s age. A large age gap (i.e. with an age range of 10–34 years) and in all these cases referral had come from social work or police sources.

**Consent to most recent sexual activity**

For 453 attendances (86%) it was recorded that the female client had consented to the most recent sexual activity. In 11 attendances there had not been consent to the most recent sexual activity. This corresponds to the 11 attendances for reported or possible rape or sexual assault in Table 3. The remaining responses were ‘not applicable’ in 38 (7.2%) and missing data in 25 (4.7%) cases. Information about history of regretted sexual intercourse was not routinely recorded.

**Age at first sexual intercourse**

Early age at first intercourse is associated with regret and with vulnerability. The median age at first intercourse was 14 years for female clients aged under 16 (Table 5). It was not possible to establish from the database how many attendances with missing data for this question were in clients who had never been sexually active.

**Are parents aware of sexual activity?**

The overwhelming majority of clients (82%) answered this question in the negative. Where details of responses to the question were recorded, the themes of inability to discuss sex with parents and fear of parental disappointment recurred.

A few clients (7.8%) were accompanied by parents or other relatives, and a smaller proportion of clients were accompanied by a social worker (2.5%). Some 55% of females attended with one or more friends. In our clinical services, clients are asked if they wish to bring an accompanying person into the consultation room, but it is explained that at some stage in the consultation we wish to see them on their own also.

![Figure 1: Length of current relationship with partner](http://jfprhc.bmj.com/)

**Table 1** Under-16 attendances and under-16 forms returned during the time period April-October 2004

<table>
<thead>
<tr>
<th>Service</th>
<th>Attendances (n)</th>
<th>Forms returned [n (%)]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>The Place</td>
<td>595</td>
<td>14</td>
</tr>
<tr>
<td>Other Sandyford services</td>
<td>370</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>965</td>
<td>26</td>
</tr>
</tbody>
</table>

**Table 2** Age of female clients with under-16 recording forms returned

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Attendances all services [n (%)]</th>
<th>Forms returned [n (%)]</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>22 (2.3)</td>
<td>3 (13.6)</td>
</tr>
<tr>
<td>13</td>
<td>62 (6.4)</td>
<td>22 (35.5)</td>
</tr>
<tr>
<td>14</td>
<td>295 (30.6)</td>
<td>165 (55.9)</td>
</tr>
<tr>
<td>15</td>
<td>586 (60.7)</td>
<td>324 (55.3)</td>
</tr>
<tr>
<td>Total</td>
<td>965 (100.0)</td>
<td>514 (53.3)</td>
</tr>
</tbody>
</table>

**Table 3** Summary of presenting problems for female clients aged under 16

<table>
<thead>
<tr>
<th>Problem</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency contraception</td>
<td>175</td>
<td>33.2</td>
</tr>
<tr>
<td>Pregnancy test</td>
<td>143</td>
<td>27.1</td>
</tr>
<tr>
<td>Contraception/contraception problems</td>
<td>116</td>
<td>22.0</td>
</tr>
<tr>
<td>STI, sexually transmitted infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assault and possible assault</td>
<td>41</td>
<td>7.8</td>
</tr>
<tr>
<td>Sexual health screen or symptoms of STIs</td>
<td>11</td>
<td>2.1</td>
</tr>
<tr>
<td>Known to be pregnant at presentation, seeking advice</td>
<td>10</td>
<td>1.9</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>3.6</td>
</tr>
<tr>
<td>Total</td>
<td>527</td>
<td>100.0</td>
</tr>
</tbody>
</table>

STI, sexually transmitted infection.
Are Fraser criteria met?
This was answered in the affirmative for 500 (94.9%) of female attendances. The ‘No’ answers included those clients who were not sexually active, those who did not consent to sex, and those for whom parents were aware of the visit.

Which staff are recording the information?
Ninety-nine percent (520/527) of forms had the staff identification number recorded. Seventy staff members returned forms over the time period, returning from 1 to 67 forms each. Seventy percent of forms were returned by 11 members of staff. All these had some clinical input to The Place clinic during the time period studied. A separate audit is being undertaken to determine whether all pertinent information is recorded in consultations where an under-16 form has not been returned, and whether specific additional training and support is required for some staff.

What child protection concerns were raised?
Staff stated they had child protection concerns about 22 female clients over the 6-month study period. Nine of these young people were ‘looked after and accommodated children’ (LaC) under the care of local social work services, who were acting in loco parentis. Twelve were not LaC but were referred to the clinic by social work or the police.

Staff expressed concern about all six female clients who stated their first sexual activity was at age 11 years. All of these clients were LaC, and had other problems (such as previous history of sexual abuse, alcohol or other drug use). Eleven clients disclosed non-consensual sex (nine who said they had recently been raped or sexually assaulted, and two who were too drunk to remember what had happened but there was some corroboration of assault). These clients were all aged 14 or 15 years, and all had been referred by police or social work services. Three of these young women were LaC at the time of the assault.

One client presented requesting help with alcohol addiction, and was referred to local social work services in addition to being seen by the clinic’s addictions worker.

Of the six female clients with partners 5 years older than themselves, four were referred to the clinic from social work or police sources. Staff did not raise concerns about the other two: a 15-year-old girl with a 20-year-old partner, whose parents were aware of the relationship and there was no social work involvement, and a 14-year-old girl with a 19-year-old boyfriend of 7 months, who was accompanied by an older cousin as she had confided in her rather than her parents. Two other clients disclosed previous older partners, but these relationships were said to have been consensual and they had ended, so social work referral was not made at that time. Some of the pregnant clients had existing support from social work services; none were referred on the basis of pregnancy alone.

Discussion
The figures for age at first sexual intercourse, and the incidence of unprotected sex (inferred from the number of requests for emergency contraception, pregnancy testing and screening for STIs), confirm that this is a client group with complex needs, and that most only seek advice from our service after the onset of sexual activity.

Most clients state they are in a relationship, with a wide variation in the duration of that relationship. As most clients only attended once in the time period studied, it was not possible to draw conclusions about the prevalence of ‘serial monogamy’ or the length of their relationships in general. Most clients were in what could be considered ‘age-appropriate’ relationships, with partners within a year of their own age. This question has been suggested as a tool to screen for exploitative coercive relationships; in our service all clients with much older partners at the time of presentation were referred by social work or police.

Consent to most recent sexual intercourse was routinely asked, and usually recorded. This question in itself may not be sensitive enough to identify those young people who felt coerced into sexual activity they now regret.

Most clients have not informed their parents or carers about their sexual activity or their visit to our service, and other research suggests that young people would be discouraged from attending sexual health service if reporting their attendance was mandatory.

The addition of the question ‘Do you have a social worker?’ (from June 2004) was meant to highlight those young people who may be particularly vulnerable. This question may not be sensitive enough; anecdotally it would seem that some young people may have contact with social work staff, but not recognise that as having ‘a social worker’. As part of the Sandyford Health Screen all clients are routinely asked at their first visit about housing status (temporary or permanent) and any problems at home, school or work. In addition, The Place staff members make an effort to ask what school clients aged under 16 years attend, and whether they go to school or not. This has not been incorporated into the recording form. These additional questions may help to identify particularly vulnerable young people, and to facilitate follow-up of vulnerable individuals.

‘Recording forms’ were completed for most consultations with clients under 16 years in our specialist young people’s service. This probably reflects a greater level of interest in and awareness of the specific needs of young people in this group of staff. The staff members with the lowest rate of completion of the forms were those who worked least frequently with young clients. This has implications for staff training and support. The low overall rate of completion of forms has been disappointing, and efforts have been made to address this.

Since October 2004, further training in child protection procedures and consultations with young people has been carried out. From October 2005, the recording of the under-16 information has been done electronically, using a secure Access database that is linked to the electronic case record.

### Table 4 Age difference between client and partner

<table>
<thead>
<tr>
<th>Age difference (years)</th>
<th>Forms returned by female clients (n = 527) [n (%)]</th>
</tr>
</thead>
<tbody>
<tr>
<td>-5 or more</td>
<td>6 (1.1)</td>
</tr>
<tr>
<td>-2 to -3</td>
<td>4 (0.8)</td>
</tr>
<tr>
<td>-1 to +1</td>
<td>308 (58.4)</td>
</tr>
<tr>
<td>+2 to +3</td>
<td>109 (20.7)</td>
</tr>
<tr>
<td>Incomplete/incorrect DOB</td>
<td>10 (1.9)</td>
</tr>
<tr>
<td>Not answered</td>
<td>66 (12.5)</td>
</tr>
</tbody>
</table>

*aNegative values indicate that the client is younger than their partner. DOB, date of birth.*

### Table 5 Age at first sexual intercourse

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Forms returned by female clients (n = 527) [n (%)]</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>6 (1.1)</td>
</tr>
<tr>
<td>12</td>
<td>13 (2.5)</td>
</tr>
<tr>
<td>13</td>
<td>67 (12.7)</td>
</tr>
<tr>
<td>14</td>
<td>200 (37.9)</td>
</tr>
<tr>
<td>15</td>
<td>174 (33.0)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>67 (12.7)</td>
</tr>
</tbody>
</table>
This should make it easier for all staff to record the information and should lead to an improvement in the proportion of forms completed. It also allows senior staff at The Place to check the records very soon after the consultation. When this new process is established we will re-evaluate the information.

How has all this activity been of use?

(a) Within the service:

- It has been of value in prompting staff to document certain components of the 16-17 consultation (e.g., ‘Fraser competence’).
- It has enabled senior staff to identify clients thought to be particularly vulnerable, and to follow their progress and reappearance at our services.
- Senior staff have not picked up major child protection issues that were missed by staff who completed the ‘recording forms’. A separate audit is in progress to establish whether documentation is full enough for those clients aged under 16 years who did not have forms completed.
- Because senior staff have examined each form, it is possible to determine patterns of presentation and identify training issues for some staff.
- Similarly, because some staff have not completed many forms, it is possible to identify their specific training needs and arrange support.

(b) External links:

- We have been able to use the information collected (once it has been anonymised) to demonstrate our typical workload and our specific areas of concern to external agencies that we liaise with (e.g. social work colleagues, the local child protection advisor and trainers, the Young People’s Health Planning and Implementation Group at the DHSS).
- We have also been able to demonstrate to external agencies the presenting problems of young people and how child protection and confidentiality principles are applied in our practice.
- Dissemination of our findings at external professional meetings has generated much discussion from fellow professionals. Some have requested copies of the proforma to assist in drafting their own versions; others have shared what information they collect in their own practice.

Conclusions

A number of conclusions can be drawn from the present study as follows:

- Most clients presenting state they are in consensual relationships.
- Most do not tell their parents of their sexual activity and this has implications for staff assessing ‘Fraser competence’ to agree to treatment.
- Most clients initially present requesting emergency contraception or pregnancy testing and the inference is that unprotected sexual intercourse is common in this group of clients before they seek our services.
- The data collected give a valuable overview of the type of issues dealt with in the clinical context and can help to target training and teaching, in addition to potentially highlighting child protection issues.
- In our practice we are exploring ways of making the collection of these data more sensitive as well as specific.
- As this is an evolving field, we would appreciate the comments of others in the spirit of sharing approaches and meeting challenges.

Statements on funding and competing interests

Funding. None identified.

Competing interests. None identified.

References

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